MDR Tracking Number: M5-04-3898-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on July 9, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visit on 04-05-04, and the prescription medications for Hydrocodone, Carisoprodol, Ibuprofen and Tramadol were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 07-30-03 to 06-28-04 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 9th day of September 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-3898-01
Name of Patient:	

Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

August 30, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in family practice. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

27 pages of records were submitted for review including TWCC forms, a review by Dr. M, and a review from ___, an attorney.

Apparently this patient had a back injury that was work related on ___. Eventually he had surgery for his condition. There is documentation the patient missed a RME and IME. According to Dr. M's review dated 12/20/03, ___ as on maintenance medications of 4 doses of Hydrocodone and Carisoprodol each.

REQUESTED SERVICE(S)
Office visit on 4/5/04, Hydrocodone, Carisoprodol, Ibuprofen, Tramadol.

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
___'s injury occurred on ___. His clinical course is sketchy because of the paucity of clinical notes submitted. Additional requests to obtain more information went unanswered. Even the clinical notes for the office visit on 4/5/04 which is a disputed service was not received. Therefore, no medical necessity could be established to justify the office visit and medications in dispute. The prior denial is upheld.